SECTION V
AODA DAY TREATMENT PROVIDER HANDBOOK
APPENDICES

APPENDIX 1A
TREATMENT CRITERIA FOR
AODA DAY TREATMENT PROGRAM (ADULT)

* *

SEVERITY OF ILLNESS
ADMISSION TO TREATMENT PROGRAM

ONE indicator from categories 1, 4, 5, and 6 and two indicators from categories 2 and 3.

1. Loss of control or relapse crisis (at least one):

   a. At time of admission imminent chemical use is likely without close monitoring and structured support; or

   b. Recipient has a documented failure to maintain abstinence with lower level of care; or

   c. Relapse would result in grave physical or personal harm to recipient.

2. Physical conditions or complications:

   a. Recipient's physical condition will benefit from AODA day treatment; and

   b. One of the following:

      - Recipient's physical condition is stable; or

      - Recipient has physical problems sufficiently severe to trigger addictive behavior and thus requires AODA day treatment (e.g., chronic pain creating the urge to seek addictive drugs).

3. Psychiatric conditions or complications:

   a. Recipient's psychiatric state will benefit from AODA day treatment; and

   b. One of the following:

      - Recipient's psychiatric state is stable; or

      - Recipient has psychological stressors sufficiently severe to result in use of chemicals if s/he does not receive treatment within the structure of a day treatment program (e.g., depression, unresolved grief, physical or sexual abuse).

4. Recovery environment (at least one):

   a. Recipient's family environment or living situation is stable enough to permit benefit from day treatment; or

   b. Family members and/or significant others are unsupportive of recovery goals. Recipient's focus on recovery is enhanced by leaving the home environment during the day, but s/he may return home because there is no active opposition by family to the recovery effort; or

   c. Instability of the recipient's living environment due to substance abuse may be remedied with AODA day treatment (e.g., threatened divorce).

APPENDIX 1A
TREATMENT CRITERIA FOR
AODA DAY TREATMENT PROGRAM (ADULT)

* *

<u>SEVERITY OF ILLNESS</u>
ADMISSION TO TREATMENT PROGRAM
(continued)

5. Life areas impairment (at least one):

   a. Recipient's chemical abuse results in significant behavioral deterioration (e.g., abuse of significant other, dishonesty, criminal charges); or

   b. Recipient's chemical abuse results in severe social dysfunction (e.g., breakdown of important personal relationships, financial irresponsibility); or

   c. Recipient's chemical abuse results in substantial loss of vocational or educational performance (e.g., significant absenteeism, occupational difficulties, school suspension).

6. Treatment acceptance/resistance (at least one):

   a. Recipient lacks sufficient understanding of the addiction disease process to undertake her/his own recovery and is willing to undergo AODA day treatment; or

   b. Recipient lacks sufficient personal responsibility for recovery to comply with a treatment program at a lower level of care and is willing to undergo AODA day treatment.

APPENDIX 1B
TREATMENT CRITERIA FOR
AODA DAY TREATMENT PROGRAM (ADOLESCENT)

* *

SEVERITY OF ILLNESS
ADMISSION TO TREATMENT PROGRAM

ONE indicator from categories 1, 5, and 6; two indicators from category 2; and ALL indicators from categories 3 and 4 must be met:

1. Loss of control or relapse crisis (at least one):

   a. At time of admission imminent chemical use is likely without close monitoring and structured support; or

   b. Recipient has a documented failure to maintain abstinence with lower level of care; or

   c. Relapse would result in grave physical or personal harm to recipient.

2. Physical conditions or complications:

   a. Recipient's physical condition will permit benefit from AODA day treatment; and

   b. One of the following:

      - Recipient's physical condition is stable; or

      - Recipient has physical problems sufficiently severe to trigger addictive behavior and thus requires AODA day treatment (example - frequent headaches creating the urge to seek addictive drugs).

3. Psychiatric conditions or complications (all of the following):

   a. Recipient's psychiatric state is stable enough to permit benefit from AODA day treatment; and

   b. Behaviors, if present, are related to chemical use problems rather than a psychiatric condition (e.g., negativistic behaviors, restlessness, sulkiness, grouchiness, verbal aggression, isolation from family activities); and

   c. If changes in moods, feelings, or attitudes are observed they are related to substance use rather than a separate condition (e.g., feelings of wanting to leave home, not being understood, lacking parental approval, not caring about personal appearance); and

   d. Documentation of substance use great enough to damage emotional health.

4. Recovery environment (all of the following):

   a. Recipient's living situation and school environment are stable enough to permit benefit from AODA day treatment; and

   b. Family conflicts related to the recipient's substance abuse may be remedied with day treatment (e.g., parents are resentful and angry about drug use); and

APPENDIX 1B
TREATMENT CRITERIA FOR
AODA DAY TREATMENT PROGRAM (ADOLESCENT)

* *

SEVERITY OF ILLNESS
ADMISSION TO TREATMENT PROGRAM
(continued)

c. Other family issues which require attention, if present, can be addressed by the program staff or through appropriate referrals (example - conflicts between the parents); and

d. Parents, foster parents, or legal guardians are supportive of recovery goals.

5. Life areas impairment (at least one):

   a. Recipient's chemical abuse results in significant behavioral deterioration (e.g., abusive behavior, dishonesty, delinquency, runaway); or

   b. Recipient's chemical abuse results in obvious social dysfunction (e.g., breakdown of important personal relationships, financial irresponsibility, association with delinquent peer group); or

   c. Recipient's chemical abuse results in substantial loss of vocational or educational performance (e.g., significant absenteeism, school suspension, impaired school performance).

6. Treatment acceptance/resistance (at least one):

   a. Recipient lacks sufficient understanding of the addiction disease process to undertake her/his own recovery and is willing to undergo AODA day treatment; or

   b. Recipient lacks sufficient personal responsibility for recovery to comply with a treatment program at a lower level of care and is willing to undergo AODA day treatment.

APPENDIX 2
TREATMENT CRITERIA FOR
AODA DAY TREATMENT PROGRAM (ADULT & ADOLESCENT)

* *

INTENSITY OF SERVICE
ALL CRITERIA MUST BE MET

I. Program Standards

Treatment must take place in a certified AODA day treatment program offering a minimum of 60 hours of intensive outpatient services on a short-term basis. For example, a typical AODA day treatment program may run for three to five hours per day, three to five days per week, for four to six weeks.

II. Diagnosis (DSM-III-R)

A. A physician has stated the recipient currently has a primary diagnosis of 303.9 (Alcohol dependence), 304.0 - 304.9 (Drug dependence), or 305.0 and 305.2 through 305.9 (Alcohol and other drug abuse).

B. The recipient does not have a primary diagnosis by a physician of mental retardation (317), alcoholic psychosis (291), drug psychosis (292), transient organic psychotic conditions (293), or acute alcohol intoxication (303.0). AODA day treatment reimbursement will be <u>denied</u> for persons with these primary diagnoses.

III. Evaluation and Treatment

A. The prior authorization request must indicate the recipient's history during at least the past twelve months of <u>all</u> treatment for alcohol or other drug abuse, including day treatment, other outpatient care, inpatient services, and detoxification, with dates of service. The request also must include a brief narrative on the recipient's previous AODA treatment outcomes.

B. If the recipient received any inpatient or day treatment for AODA in the past twelve months, the request must explain why in the opinion of the professional staff the requested AODA day treatment program is necessary and effective. Such requests will receive intensive scrutiny by the Department of Health and Social Services, according to the following:

1. Whether AODA day treatment is appropriate in the context of previous treatment;

2. Whether AODA day treatment will have a more successful outcome than the previous treatments;

3. Whether the intensity and design of the AODA day treatment program (frequency, duration and length of sessions) are likely to achieve intended results.

C. The request must document the professional staff's judgement that the recipient has a reasonable potential to improve his/her likelihood of remaining chemically free in a less structured environment after completion of AODA day treatment.

D. The treatment plan must contain measurable active treatment goals and objectives. At a minimum, the plan must address goals related to the recipient's selected "Severity of Illness" indicators.

APPENDIX 2
TREATMENT CRITERIA FOR
AODA DAY TREATMENT PROGRAM (ADULT & ADOLESCENT)

* *

INTENSITY OF SERVICE
ALL CRITERIA MUST BE MET
(continued)

E. The treatment plan must note any special needs of the recipient, such as physical health conditions, secondary psychiatric disorders, learning disabilities, nutritional needs, parenting, leisure time needs, and legal status. The plan must state how these needs have been assessed and what action has or will be taken to meet these needs in the context of AODA day treatment. The request must document that treatment efforts among various providers are coordinated, if the recipient is receiving treatment for other conditions or by other providers.

F. The treatment plan must:

   1. Describe family involvement in treatment planning, if applicable;

   2. Contain a statement that the recipient agrees to maintain abstinence throughout the course of AODA day treatment; and

   3. Include a plan for continuing care for 6-12 months after completion of AODA day treatment.

G. The treatment plan should encourage involvement in ongoing support programs such as self-help groups, if applicable.

APPENDIX 3
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

* *

ELEMENT 1 - PROCESSING TYPE
Enter the appropriate three-digit processing type from the list below. The "process type" is a three-digit code used to identify a category of service requested. Use 999 - "Other" only if the requested category of service is not found in the list. Prior Authorization and Spell of Illness requests will be returned without adjudication if no processing type is indicated.

**111 - Physical Therapy
**112 - Occupational Therapy
**113 - Speech Therapy/Audiology
**114 - Physical Therapy (spell of illness only)
**115 - Occupational Therapy (spell of illness only)
**116 - Speech Therapy (spell of illness only)
117 - Physician Services (includes Family Planning Clinic and Rural Health)
118 - Chiropractic
*120 - Home Health/Independent Nurse Services/Home Health Therapy
121 - Personal Care Services
122 - Vision
126 - Psychotherapy (HCFA 1500 billing providers only)
127 - Psychotherapy (UB-82 billing providers only)
128 - AODA Services (other than Day Treatment)
129 - Mental Health Day Treatment Services (not AODA Day Treatment)
130 - Durable Medical Equipment
131 - Drugs
132 - Disposable Medical Supplies
133 - Transplant Services
134 - AIDS Services (hospital and nursing home)
135 - Ventilator Services (hospital and nursing home)
136 - AODA Day Treatment
999 - Other (use only if the requested category of service is not listed above)

* Includes PT, OT, Speech
** Includes Rehabilitation Agencies

ELEMENT 2 - RECIPIENT'S MEDICAL ASSISTANCE IDENTIFICATION NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S NAME
Enter the recipient's last name, followed by first name and middle initial, exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S ADDRESS
Enter the address of the recipient's place of residence; the street, city, state, and zip code must be included. If the recipient is a resident of a nursing home or other facility, also include the name of the nursing home or facility.

ELEMENT 5 - RECIPIENT'S DATE OF BIRTH
Enter the recipient's date of birth in MM/DD/YY format (e.g., June 8, 1941, would be 06/08/41), as it appears on the recipient's Medical Assistance identification card.

APPENDIX 3
INSTRUCTIONS FOR THE COMPLETION OF THE
PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

* *

ELEMENT 6 - RECIPIENT'S SEX
Enter an "X" to specify male or female.

ELEMENT 7 - BILLING PROVIDER'S NAME, ADDRESS AND ZIP CODE
Enter the name and complete address (street, city, state, and zip code) of the billing provider. **No other information should be entered in this element since it also serves as a return mailing label.**

ELEMENT 8 - BILLING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including the area code, of the office, clinic, facility, or place of business of the billing provider.

ELEMENT 9 - BILLING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the billing provider.

ELEMENT 10 - RECIPIENT'S PRIMARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description most relevant to the service/procedure requested.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

ELEMENT 11 - RECIPIENT'S SECONDARY DIAGNOSIS
Enter the appropriate International Classification of Disease, 9th Edition, Clinical Modification (ICD-9-CM) diagnosis code and description additionally descriptive of the recipient's clinical condition.

NOTE: Pharmacists, medical vendors, and individual medical suppliers may provide a written description only.

ELEMENT 12 - START DATE OF SPELL OF ILLNESS
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of onset for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

ELEMENT 13 - FIRST DATE OF TREATMENT
DO NOT COMPLETE THIS ELEMENT UNLESS REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS. Enter the date of the first treatment for the spell of illness in MM/DD/YY format (e.g., March 1, 1988, would be 03/01/88).

ELEMENT 14 - PROCEDURE CODE(S)
Enter the appropriate Revenue, HCPCS, or National Drug Code (NDC) procedure code for each service/procedure/item requested, in this element. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 15 - MODIFIER
Enter the modifier corresponding to the procedure code (if a modifier is required by WMAP policy and the coding structure used) for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

APPENDIX 3
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

* *

ELEMENT 16 - PLACE OF SERVICE
Enter the appropriate place of service code designating where the requested service/procedure/item would be provided/performed/dispensed.

Code	Description
0	Other
1	Inpatient Hospital
2	Outpatient Hospital
3	Office
4	Home
7	Nursing Home
8	Skilled Nursing Facility
9	Ambulance

Alpha	Description
A	Independent Lab
B	Ambulatory Surgical Center

NOTE: Mental health services may not be provided in the recipient's home (POS 4).

ELEMENT 17 - TYPE OF SERVICE
Enter the appropriate type of service code for each service/procedure/item requested. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

Numeric	Description
0	Blood
1	Medical (including: Physician's Medical Services, Home Health, Independent Nurses, Audiology, PT, OT, ST, Personal Care, AODA, Day Treatment, and AODA Day Treatment)
2	Surgery
3	Consultation
4	Diagnostic X-Ray - Total Charge
5	Diagnostic Lab - Total Charge
6	Radiation Therapy - Total Charge
7	Anesthesia
8	Assistant Surgery
9	Other including: Transportation *Non-MD Psych Family Planning Clinic Rehabilitation Agency Nurse Midwife Chiropractic

* non-Board operated only

APPENDIX 3
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

* *

Alpha	
B	Diagnostic Medical - Total
C	Ancillaries, Hospital and Nursing Home
D	Drugs
E	Accommodations, Hospital and Nursing Home
F	Free Standing Ambulatory Surgical Center
G	Dental
J	Vision Care and Cataract Lens
K	Nuclear Medicine - Total Charge
P	Purchase New DME
Q	Diagnostic X-Ray - Professional
R	DME Rental
S	Radiation Therapy - Professional
T	Nuclear Medicine - Professional
U	Diagnostic X-Ray, Medical - Technical
W	Diagnostic Medical - Professional
X	Diagnostic Lab - Professional

ELEMENT 18 - DESCRIPTION OF SERVICE
Enter a written description corresponding to the appropriate Revenue, HCPCS or National Drug Code (NDC) procedure code for each service/procedure/item requested.

NOTE: If you are requesting a therapy spell of illness, enter "Spell of Illness" in this element.

When requesting home health/personal care services, indicate the number of hours per day/number of days per week times the total number of weeks being requested.

ELEMENT 19 - QUANTITY OF SERVICE REQUESTED
Enter the quantity (e.g., number of services, dollar amount) requested for each service/procedure/item requested.

AODA (number of services)
AODA Day Treatment (number of hours)
Audiology (number of services)
Chiropractic (number of adjustments)
Day Treatment (number of services)
Dental (number of services)
Disposable Medical Supplies (number of days supply)
Drugs (number of days supply)
Durable Medical Equipment (number of services)
Hearing Aid (number of services)
Home Health (number of units)/Independent Nurses (number of units)
Home Health Therapy-PT, OT, Speech (number of visits)
Hospital Transplant (per hospital stay)
Hospital and Nursing Home AIDS Services (number of days)
Hospital and Nursing Home Ventilator Services (number of days)
Occupational Therapy (number of services)

APPENDIX 3
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION REQUEST FORM (PA/RF)

* *

Occupational Therapy (spell of illness only) (enter 35)
Orthodontics (dollar amount)
Personal Care (number of hours)
Physical Therapy (number of services)
Physical Therapy (spell of illness only) (enter 35)
Physician (number of services)
Psychotherapy (HCFA 1500 billing providers only) (number of services)
Psychotherapy (UB-82 billing providers only) (dollar amount)
Speech Therapy (number of services)
Speech Therapy (spell of illness only) (enter 35)
Transportation (number of services) (mileage)
Vision (number of services)

NOTE: If requesting a therapy spell of illness, enter "35" in this element.

ELEMENT 20 - CHARGES
Enter your usual and customary charge for each service/procedure/item requested. If the quantity is greater than "1", multiply the quantity by the charge for each service/procedure/item requested. Enter that total amount in this element. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

NOTE:
The charges indicated on the <u>request form</u> should reflect the provider's usual and customary charge for the procedure requested. Providers are reimbursed for authorized services according to <u>Terms of Provider Reimbursement</u> issued by the Department of Health and Social Services.

ELEMENT 21 - TOTAL CHARGE
Enter the anticipated total charge for this request. DO NOT COMPLETE THIS ELEMENT IF REQUESTING A THERAPY (PT, OT, SPEECH) SPELL OF ILLNESS.

ELEMENT 22 - BILLING CLAIM PAYMENT CLARIFICATION STATEMENT
"An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO."

ELEMENT 23 - DATE
Enter the month, day, and year (in MM/DD/YY format) the prior authorization request form was completed and signed.

ELEMENT 24 - REQUESTING PROVIDER'S SIGNATURE
The signature of the provider requesting/performing/dispensing the service/procedure/item must appear in this element.

DO NOT ENTER ANY INFORMATION BELOW THE SIGNATURE OF THE REQUESTING PROVIDER -- THIS SPACE IS RESERVED FOR THE WISCONSIN MEDICAL ASSISTANCE PROGRAM CONSULTANT(S) AND ANALYST(S).

APPENDIX 4

4H5-015

MAIL TO:
E.D.S. FEDERAL CORPORATION
PRIOR AUTHORIZATION UNIT
6406 BRIDGE ROAD
SUITE 88
MADISON, WI 53784-0088

PRIOR AUTHORIZATION REQUEST FORM

PA/RF (DO NOT WRITE IN THIS SPACE)

ICN #
A.T. #
P.A. # 1234567

1 PROCESSING TYPE: 136

2 RECIPIENT'S MEDICAL ASSISTANCE ID NUMBER: 1234567890

3 RECIPIENT'S NAME (LAST, FIRST, MIDDLE INITIAL): Recipient Im A.

4 RECIPIENT ADDRESS (STREET, CITY, STATE, ZIP CODE): 609 Willow, Anytown, WI 53725

5 DATE OF BIRTH: 03/30/57

6 SEX: M [X] F [ ]

8 BILLING PROVIDER TELEPHONE NUMBER: (XXX) XXX-XXXX

7 BILLING PROVIDER NAME, ADDRESS, ZIP CODE:
I.M. Provider
1 W. Williams
Anytown, WI 53725

9 BILLING PROVIDER NO.: 87654321

10 DX: PRIMARY: 303.9

11 DX: SECONDARY: 305.2

12 START DATE OF SOI: n/a

13 FIRST DATE RX: n/a

14 PROCEDURE CODE	15 MOD	16 POS	17 TOS	18 DESCRIPTION OF SERVICE	19 QR	20 CHARGES
W8982		2	1	AODA Day Treatment	64 hrs	XXX.XX
					TOTAL CHARGE	21 XXX.XX

22. An approved authorization does not guarantee payment. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medical Assistance Program payment methodology and Policy. If the recipient is enrolled in a Medical Assistance HMO at the time a prior authorized service is provided, WMAP reimbursement will be allowed only if the service is not covered by the HMO.

23 MM/DD/YY — DATE

24 I.M. Provider — REQUESTING PROVIDER SIGNATURE

(DO NOT WRITE IN THIS SPACE)

AUTHORIZATION:

[ ] APPROVED — GRANT DATE — EXPIRATION DATE — PROCEDURE(S) AUTHORIZED — QUANTITY AUTHORIZED

[ ] MODIFIED — REASON:

[ ] DENIED — REASON:

[ ] RETURN — REASON:

DATE — CONSULTANT/ANALYST SIGNATURE

482-120

APPENDIX 5
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION AODA DAY TREATMENT ATTACHMENT (PA/ADTA)

* *

The timely determination of authorization is significantly enhanced by the completeness and quality of the documentation submitted by providers when requesting prior authorization. Any AODA day treatment services that require the Prior Authorization Request Form (PA/RF) will also require a completed PA/ADTA. Carefully complete this PA/ADTA form, attach it to the PA/RF, and submit to the following address:

E.D.S. Federal Corporation
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

Questions regarding completion of the PA/RF and/or the PA/ADTA may be addressed to the EDS Telephone/Written Correspondence Unit.

<u>RECIPIENT INFORMATION</u>:

ELEMENT 1 - RECIPIENT'S LAST NAME
Enter the recipient's last name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 2 - RECIPIENT'S FIRST NAME
Enter the recipient's first name exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 3 - RECIPIENT'S MIDDLE INITIAL
Enter the recipient's middle initial exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 4 - RECIPIENT'S MEDICAL ASSISTANCE NUMBER
Enter the recipient's ten-digit Medical Assistance identification number exactly as it appears on the recipient's Medical Assistance identification card.

ELEMENT 5 - RECIPIENT'S NUMERICAL AGE
Enter the age of the recipient in numerical form (e.g., 45, 60, 21).

<u>PROVIDER INFORMATION</u>:

ELEMENT 6 - REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS
Enter the name and credentials of the therapist who will be providing treatment/service.

ELEMENT 7 - REQUESTING/PERFORMING PROVIDER NUMBER
Enter the eight-digit Medical Assistance provider number of the requesting/performing provider, if available.

ELEMENT 8 - REQUESTING/PERFORMING PROVIDER'S TELEPHONE NUMBER
Enter the telephone number, including area code, of the requesting/performing provider.

ELEMENT 9 - REFERRING/PRESCRIBING PROVIDER'S NAME
Enter the name of the provider referring/prescribing treatment.

ELEMENT 10 - REFERRING/PRESCRIBING PROVIDER'S NUMBER
Enter the eight-digit Medical Assistance provider number of the referring/prescribing provider.

APPENDIX 5
INSTRUCTIONS FOR THE COMPLETION OF THE PRIOR AUTHORIZATION AODA DAY TREATMENT ATTACHMENT (PA/ADTA)

* *

The remaining portions of this attachment are to be used to document the justification for the service requested. Refer to Appendices 1 and 2 for criteria which must be addressed.

AODA DAY TREATMENT IS NOT A COVERED SERVICE FOR RECIPIENTS WHO ARE RESIDENTS OF A NURSING HOME OR WHO ARE HOSPITAL INPATIENTS.

1. Complete elements A through H. Indicate in element B if this referral is a HealthCheck referral and, if it is, attach a of the HealthCheck billing claim form signed and dated within one year of the ICN date of request. Allowable DSM-III diagnoses are 303.90 (alcohol dependence), 304.0 through 304.90 (drug dependence), 305.00 (alcohol abuse), or 305.20 through 305.90 (alcohol and other drug abuse).

2. Attach a photocopy of the physician's current prescription for AODA day treatment to the attachment form. The prescription must be dated and signed within one month of receipt by EDS. NOTE: If a physician will be the performing provider, a prescription need not be attached.

3. The attachment form must be dated and signed by the provider requesting/providing the service/procedure.

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/ADTA

PRIOR AUTHORIZATION
AODA DAY TREATMENT ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

1	2	3	4	5
Recipient	Im	A	1234567890	32
LAST NAME	FIRST NAME	MIDDLE INITIAL	MEDICAL ASSISTANCE ID NUMBER	AGE

PROVIDER INFORMATION

6	7	8
I.M. Provider	87654321	(XXX) XXX - XXXX
REQUESTING/PERFORMING PROVIDER'S NAME AND CREDENTIALS	REQUESTING/PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	REQUESTING/PERFORMING PROVIDER'S TELEPHONE NUMBER

9	10
I.M. Referring	12345678
REFERRING/PRESCRIBING PROVIDER'S NAME	REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER

A. LENGTH AND INTENSITY OF TREATMENT REQUESTED

- Program request is for 4 hours per day
  4 days per week
  for 4 weeks
  for a total of 64 hours.
- Anticipated beginning treatment date 3/20/89
- Estimated AODA Day Treatment discharge date 4/14/89
- Attach a copy of treatment design, which includes the following:
  a) Schedule of treatment (day, time of day, length of session and service to be provided during that time) (PROGRAM SCHEDULE ATTACHED)
  b) Brief description of aftercare/continuing care/follow-up component (also include this information in treatment plan section below.) Each recipient will be referred to at least 12 weeks of group therapy consisting of one 90-minute group per week.

B. DIAGNOSIS

- Dates of diagnostic evaluations or medical examinations:
  3/15/89--clinical interview and assessment
  3/17/89--psychiatric team staffing
  3/18/89--medical exam
- Specific diagnostic procedures which were employed:
  Clinical intake tool used at our agency
  MAST
  MMPI

- Recipient's current primary and secondary diagnosis codes (DSM-III-R) and descriptions:
  Primary-303.90(Alcohol dependence), as manifested by loss of control, periods of attempted abstinence, morning agitation and tremor, continued use of alcohol in spite of ulcer and high blood pressure, increased tolerance, and inability to secure employment.

  Secondary-305.20 (Cannabis abuse), as manifested by periodic use despite social problems associated with use, pattern of use over past four years.

C. HISTORY

- Describe the recipient's **current** clinical problems and relevant clinical history, including AODA history.
  Recipient presents at our clinic with suicidal ideation, difficulty sleeping, negative self-abuse references, recently separated from spouse because of drinking incident.
  Recipient reports drinking 3 to 5 times per week, consuming 6 to 15 beers per occasion. Reports history of loss of control, blackouts, OWI's, and loss of job associated with use. In addition, recipient is continuing to drink despite ulcer and high blood pressure. History of periods of abstinence over past 10 years. Recipient also reports weekly to monthly use of "pot." Denies other substance use.
  Recipient seems motivated for treatment and has agreed to abstinence from all psychoactive substances.
  In addition, recipient claims positive history of family alcoholism for at least 2 generations. Recipient has no children and currently lives with friend while in separation period.

- Has the recipient received **any** AODA treatment in the past twelve months?
  _X_ YES ____ NO

- If YES, provide information on date of each treatment episode, type of service provided, and treatment outcomes.
  About one year ago, recipient was arrested for OMVWI and had weekly outpatient counseling as a condition to continued driving privileges. Recipient reports he was not able to abstain during that period and fabricated his use history.

- If the recipient received any inpatient AODA care, intensive outpatient AODA services or AODA Day Treatment in the past twelve months, please give rationale for appropriateness and medical necessity of current request. Please discuss projected outcome of additional treatment requested.

  Not applicable

D. SEVERITY OF ILLNESS

- Describe the recipient's severity of illness using the following indicators.
  Please refer to the AODA Day Treatment criteria.

1. Loss of control/relapse crisis: As reported, recipient is very likely to continue use without close monitoring. Also, recipient has only been able to abstain for 7 to 10 days without structure. Abstinence will be monitored as well as withdrawal possibilities.

2. Physical conditions or complications: Though recipient has ulcer and high blood pressure, our M.D., after evaluation, feels that he is stable enough to benefit from program. Our nurse on staff will monitor withdrawal symptoms.

3. Psychiatric conditions or complications: Recipient has signs of depression. However, it is felt these are more a consequence of the substance abuse and not its cause. In any event, underlying depression will be evaluated.

4. Recovery environment: Current instability of the recipient's living environment will be greatly remedied by day treatment. (Spouse has agreed to attend family education component and receive supportive outpatient therapy).

5. Life areas impairment: Recipient's use history indicates impairments in relationships with spouse, OWI's, and financial and vocational difficulties.

6. Treatment acceptance/resistance: Recipient is willing to become involved with treatment. This is demonstrated by his commitment to abstain, attend all sessions, and participate in counseling with spouse.

E. TREATMENT PLAN

- Attach a copy of the recipient's AODA Day Treatment plan (please refer to intensity of service guideline in the AODA Day Treatment criteria).
  (CLINICAL TREATMENT PLAN USED IN RECIPIENT'S CASE FILE ATTACHED)
- Describe any special needs of the recipient and indicate how these will be addressed (for example, educational needs, access to treatment facility).
  Recipient will be brought to clinic on first day of treatment by spouse. After that, he will be introduced to our "volunteer drivers" program and he will be responsible to ask for ride shares.

- Describe the recipient's family situation. Indicate how family issues will be addressed in treatment, if applicable. If family members are not involved in treatment, explain why not. Recipient has been married 10 years, no children. He on occasion has been verbally abusive to spouse. Spouse has attempted to "shelter" him from consequences of his own drinking. She has agreed to attend all lectures open to family members. She also has agreed to be seen by a psychotherapist to deal with her co-dependency issues and own depression. She is motivated for couples work when recipient is more stable.

- Briefly describe treatment goals and objectives.

1. Recipient agreed to abstain from pot and alcohol use.
2. Recipient will prepare own AODA history by end of the first week.
3. Recipient will verbalize history to group by end of the second week.
4. Recipient will begin to understand centrality of alcohol in family of origin and in own life.
5. Recipient will begin to identify and express feelings by the end of 4th week.
6. Recipient will show beginning emotional grieving needed in recovery.
7. Recipient will attend at least 2 AA/week.

- Please describe the expected outcomes of treatment including the plan for continuing care.

1. Recipient will have cycle of addiction interrupted.
2. Will agree to 12 weeks of aftercare.
3. Will begin to develop self-support system, including sponsor for 6 - 12 months after treatment.
4. Will understand concepts of shame, victimization, and emotional grief as issues of the recovery.
5. Will develop self-reflective skills.
6. Will understand the addictive disease process.

COUNTY RECOMMENDATION (OPTIONAL) If the County Human Services Department or 51.42 Board has made a recommendation on this request, documentation may be attached. THIS INFORMATION IS OPTIONAL.

F. RECIPIENT AUTHORIZATION

I have read the attached request for prior authorization of AODA Day Treatment services and agree that it will be sent to the Medical Assistance Program for review.

Im A. Recipient
Signature of recipient or representative (if representative, state relationship)

Relationship to recipient

G. Attach a photocopy of the physician's current prescription for AODA Day Treatment. (Must be dated within one month of receipt at EDS).

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NONPAYMENT OF THE BILLING CLAIM(S).

H. P. M. Performing
Signature of Performing Provider

M.S.
Discipline of Performing Provider

I.M. Supervising, M.D.
Name of Supervising Physician or Psychologist

87654321
Provider Number of Supervising Provider

P. M. Supervising
Signature of Supervising Physician or Psychologist

MM/DD/YY
Date

APPENDIX 7
NATIONAL HCFA 1500 CLAIM FORM COMPLETION INSTRUCTIONS FOR AODA DAY TREATMENT SERVICES
(For Claims Received on or after January 4, 1993)

To avoid denial or inaccurate claim payment, providers must use the following claim form completion instructions. Enter all required data on the claim form in the appropriate element. Do not include attachments unless instructed to do so. All elements are required unless "not required" is specified.

Wisconsin Medical Assistance recipients receive a Medical Assistance identification card upon initial enrollment into the Wisconsin Medical Assistance Program (WMAP) and at the beginning of each month thereafter. Providers should always see this card before rendering services. Please use the information exactly as it appears on the Medical Assistance identification card to complete the patient and insured information.

ELEMENT 1 - Program Block/Claim Sort Indicator
Enter claim sort indicator "M" for the service billed in the Medicaid check box. Claims submitted without this indicator are denied.

ELEMENT 1a - INSURED'S I.D. NUMBER
Enter the recipient's ten-digit Medical Assistance identification number as found on the current Medical Assistance identification card. This element must contain no other numbers, unless the claim is a Medicare crossover claim, in which case the recipient's Medicare number may also be indicated.

ELEMENT 2 - PATIENT'S NAME
Enter the recipient's last name, first name, and middle initial as it appears on the current Medical Assistance identification card.

ELEMENT 3 - PATIENT'S BIRTH DATE, PATIENT'S SEX
Enter the recipient's birth date in MM/DD/YY format (e.g., February 3, 1955, would be 02/03/55) as it appears on the Medical Assistance identification card. Specify if male or female with an "X."

ELEMENT 4 - INSURED'S NAME (not required)

ELEMENT 5 - PATIENT'S ADDRESS
Enter the complete address of the recipient's place of residence.

ELEMENT 6 - PATIENT RELATIONSHIP TO INSURED (not required)

ELEMENT 7 - INSURED'S ADDRESS (not required)

ELEMENT 8 - PATIENT STATUS (not required)

ELEMENT 9 - OTHER INSURED'S NAME
Third party insurance (commercial insurance coverage) must be billed prior to billing the WMAP, unless the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook.

- When the provider has not billed other insurance because the "Other Coverage" of the recipient's Medical Assistance identification card is blank, the service does not require third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, or the recipient's Medical Assistance identification card indicates "DEN" only, this element must be left blank.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates HPP, BLU, WPS, CHA, or OTH and the service requires third party billing according to Appendix 18a of Part A of the WMAP Provider Handbook, one of the following codes MUST be indicated in the first box of element 9. The description is not required, nor is the policyholder, plan name, group number, etc. (Elements 9a, 9b, 9c, and 9d are not required.)

Code	Description
OI-P	PAID in part by other insurance. The amount paid by private insurance to the provider or the insured is indicated on the claim.
OI-D	DENIED by private insurance following submission of a correct and complete claim, or payment was applied towards the coinsurance and deductible. DO NOT use this code unless the claim in question was actually billed to the private insurer.
OI-Y	YES, card indicates other coverage but it was not billed for reasons including, but not limited to: - Recipient denies coverage or will not cooperate; - The provider knows the service in question is noncovered by the carrier; - Insurance failed to respond to initial and follow-up claim; or - Benefits not assignable or cannot get an assignment.

- When "Other Coverage" of the recipient's Medical Assistance identification card indicates "HMO" or "HMP", one of the following disclaimer codes must be indicated, if applicable:

Code	Description
OI-P	PAID by HMO or HMP. The amount paid is indicated on the claim.
OI-H	HMO or HMP does not cover this service or the billed amount does not exceed the coinsurance or deductible amount.

Important Note: The provider may not use OI-H if the HMO or HMP denied payment because an otherwise covered service was not rendered by a designated provider. Services covered by an HMO or HMP are not reimbursable by the WMAP except for the copayment and deductible amounts. Providers who receive a capitation payment from the HMO may not bill the WMAP for services which are included in the capitation payment.

ELEMENT 10 - IS PATIENT'S CONDITION RELATED TO (not required)

ELEMENT 11 - INSURED'S POLICY, GROUP OR FECA NUMBER
The first box of this element is used by the WMAP for Medicare information. (Elements 11a, 11b, 11c, and 11d are not required.) When the recipient's Medical Assistance identification card indicates Medicare coverage, enter Medicare disclaimer code "M-8," since AODA day treatment is not a Medicare benefit.

ELEMENTS 12 AND 13 - AUTHORIZED PERSON'S SIGNATURE
(Not required since the provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 14 - DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (not required)

ELEMENT 15 - IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS (not required)

ELEMENT 16 - DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (not required)

ELEMENT 17 - NAME OF REFERRING PHYSICIAN OR OTHER SOURCE
When required, enter the referring or prescribing physician's name.

ELEMENT 17a - I.D. NUMBER OF REFERRING PHYSICIAN
When required, enter the referring provider's six-character UPIN number. If the UPIN number is not available, enter the WMAP provider number or license number of the referring provider.

ELEMENT 18 - HOSPITALIZATION DATES RELATED TO CURRENT SERVICES (not required)

ELEMENT 19 - RESERVED FOR LOCAL USE (not required)

ELEMENT 20 - OUTSIDE LAB (not required)

ELEMENT 21 - DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
The International Classification of Disease, Ninth Edition, Clinical Modification (ICD-9-CM) diagnosis code must be entered for each symptom or condition related to the services provided. Manifestation ("M") codes are not acceptable. List the primary diagnosis first. Etiology ("E") codes may not be used as a primary diagnosis. The diagnosis description is not required.

ELEMENT 22 - MEDICAID RESUBMISSION (not required)

ELEMENT 23 - PRIOR AUTHORIZATION
Enter the seven-digit prior authorization number from the approved prior authorization request form. Do not attach a copy of the prior authorization to the claim. Services authorized under multiple prior authorizations must be billed on separate claim forms with their respective prior authorization numbers.

ELEMENT 24A - DATE(S) OF SERVICE
Enter the month, day, and year for each procedure using the following guidelines:

- When billing for one date of service, enter the date in MM/DD/YY format in the "From" field.
- When billing for two, three, or four dates of service on the same line, enter the first date of service in MM/DD/YY format in the "From" field, and subsequent dates of service in the "To" field by listing only the date(s) of the month (i.e., DD, DD/DD, or DD/DD/DD)

It is allowable to enter up to four dates of service per line if:

- All dates of service are in the same calendar month.
- All services performed are identical.
- All procedures have the same type of service code.
- All procedures have the same place of service code.

- All procedures were performed by the same provider.
- The same diagnosis is applicable for each procedure.
- The charge for all procedures is identical. (Enter the total charge per detail line in element 24F.)
- The number of services performed on each date of service is identical.
- All procedures have the same HealthCheck or family planning indicator.
- All procedures have the same emergency indicator.

ELEMENT 24B - PLACE OF SERVICE
Enter the appropriate WMAP single-digit place of service code for each service.

Code	Description
2	outpatient hospital
3	office

ELEMENT 24C - TYPE OF SERVICE CODE
Enter type of service code "1."

ELEMENT 24D - PROCEDURES, SERVICES, OR SUPPLIES
Enter the appropriate five-character procedure code. The procedure codes for AODA day treatment are listed below:

Code	Description
W8980	AODA Day Treatment Assessment (up 3 hours per calendar year)
W8981	AODA Day Treatment Assessment (annual 3-hour limitation exceeded; requires prior authorization)
W8982	AODA Day Treatment (requires prior authorization)

ELEMENT 24E - DIAGNOSIS CODE
When multiple procedures related to different diagnoses are submitted, column E must be used to relate the procedure performed (element 24D) to a specific diagnosis in element 21. Enter the number (1, 2, 3, or 4) which corresponds to the appropriate diagnosis in element 21.

ELEMENT 24F - CHARGES
Enter the total charge for each line.

ELEMENT 24G - DAYS OR UNITS
Enter the total number of services billed on each line item. All AODA day treatment services are one hour procedure codes. When billing for fractions of an hour, indicate units of service in half-hour increments using the standard rules of rounding.)

ELEMENT 24H - EPSDT/FAMILY PLANNING
Enter an "H" for each procedure that was performed as the result of a HealthCheck (EPSDT) referral.

ELEMENT 24I - EMG
Enter an "E" for each procedure performed as an emergency, regardless of the place of service.

ELEMENT 24J - COB (not required)

ELEMENT 24K - RESERVED FOR LOCAL USE
When applicable, enter the word "spenddown" and under it, the spenddown amount on the last detail line of element 24K directly above element 30. Refer to Section IX of Part A of the WMAP Provider Handbook for information on recipient spenddown.

ELEMENT 25 - FEDERAL TAX ID NUMBER (not required)

ELEMENT 26 - PATIENT'S ACCOUNT NO.
Optional - provider may enter up to 12 characters of the patient's internal office account number. This number will appear on the EDS Remittance and Status Report.

ELEMENT 27 - ACCEPT ASSIGNMENT
(Not required, provider automatically accepts assignment through Medical Assistance certification.)

ELEMENT 28 - TOTAL CHARGE
Enter the total charges for this claim.

ELEMENT 29 - AMOUNT PAID
Enter the amount paid by other insurance. If the other insurance denied the claim, enter $0.00. (If a dollar amount is indicated in element 29, "OI-P" must be indicated in element 9.)

ELEMENT 30 - BALANCE DUE
Enter the balance due as determined by subtracting the recipient spenddown amount in element 24K and the amount paid in element 29 from the amount in element 28.

ELEMENT 31 - SIGNATURE OF PHYSICIAN OR SUPPLIER
The provider or the authorized representative must sign in element 31. The month, day, and year the form is signed must also be entered in MM/DD/YY format.

NOTE: This may be a computer-printed or typed name and date, or a signature stamp with the date.

ELEMENT 32 - NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (not required)

ELEMENT 33 - PHYSICIAN'S, SUPPLIERS BILLING NAME, ADDRESS, ZIP CODE AND PHONE #
Enter the provider's name (exactly as indicated on the provider's notification of certification letter) and address of the billing provider. At the bottom of element 33, enter the billing provider's eight-digit Medical Assistance provider number.

APPENDIX 8
SAMPLE NATIONAL HCFA 1500 CLAIM FORM

HEALTH INSURANCE CLAIM FORM PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare #) MEDICAID [M] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): 1234567890

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): Recipient, Im A.

3. PATIENT'S BIRTH DATE MM DD YY: MM DD YY SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 609 Willow

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: Anytown STATE: WI

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ]

CITY: STATE:

ZIP CODE: 55555 TELEPHONE (Include Area Code): (XXX) XXX-XXXX

Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial): OI-P

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [ ]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [ ] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [ ] If yes, return to and complete item 9 a-d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS, GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE: I.M.Referring

17a. I.D. NUMBER OF REFERRING PHYSICIAN: 87654321

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. 303.9 3. ____

2. ____ 4. ____

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER: 1234567

PHYSICIAN OR SUPPLIER INFORMATION

24 A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B Place of Service	C Type of Service	D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E DIAGNOSIS CODE	F $ CHARGES	G DAYS OR UNITS	H EPSDT Family Plan	I EMG	J COB	K RESERVED FOR LOCAL USE
1 02 11 92	12 13 14	2	1	W8982		1	XXX XX	16				
2 02 18 92	19 20	2	1	W8982		1	XXX XX	12				
3												
4												
5												
6												spenddown XX.XX

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.: 1234JED

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. TOTAL CHARGE: $ XXX XX

29. AMOUNT PAID: $ XXX XX

30. BALANCE DUE: $ XXX XX

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

I.M.Provider MM/DD/YY

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

I.M.Billing
1 W. Williams
Anytown, WI 55555

PIN# GRP# 12345678

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8-88) **PLEASE PRINT OR TYPE** FORM HCFA-1500 (U2) (12-90) FORM OWCP-1500 FORM RRB-1500